PRINTED: 12/24/2013 FORM APPROVED OMB NO. 0938-0391

	REMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		175532	B. WING _	B. WING			C 1 19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT R	EEDS COVE		STREET ADDRESS, 2114 N 127TH CT E WICHITA, KS 672		, 12,	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	IVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F (000			
	partially-extended cor complaint numbers ## A revised copy of defi	iciencies was electronically					
F 225 SS=D		c)(2) - (4) DRT	Fí	225			
	been found guilty of a mistreating residents had a finding entered registry concerning al of residents or misapp and report any knowle court of law against a indicate unfitness for	employ individuals who have abusing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a n employee, which would service as a nurse aide or ne State nurse aide registry s.					
	involving mistreatmer including injuries of un misappropriation of re immediately to the ad to other officials in acc	nknown source and esident property are reported ministrator of the facility and cordance with State law procedures (including to the					
	•						
	The results of all inve	stigations must be reported					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AND DUAN OF CODDECTION IDENTIFICATION NUMBER		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		175532	B. WING _			C 12/19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE	•	STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	<u>'</u>	12/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	with State law (inclu- certification agency incident, and if the a	_	F 2	25		
	by: The facility census residents included i were reviewed for rorigin to the state. E review of a closed rimmediately report	totaled 52 residents with 7 in the sample. Of those, all 7 eporting of injuries of unknown based on interview and record ecord, the facility failed to an incident involving fractured vey and certification agency esidents. (#3)				
	orders sheet dated including the following complications (when there's not enough respond to the insult condition when the body becomes conguinability of the kidn concentrate urine a depressive disorder the prostate.	at #3's signed physician's 11/4/13 revealed diagnoses ng: type 2 diabetes without in the body can't use glucose, insulin made or the body can't in), congestive heart failure (a theart output is low and the gested with fluid), renal failure eys to excrete wastes, ind conserve electrolytes), in, and inflammatory disease of ard face sheet revealed the in the facility on 9/30/13.				
	Review of the reside	ent's Admission MDS				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		175532	B. WING			C 2/19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	<u> </u>	2.10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	revealed the resider for Mental Status) simpairment). It reve limited assist of 2 person for locomotion. The resprior to admission, admission, but had admission. Review of the Fall C for Admission MDS limited to extensive transfers and ambut for falls. The resider ambulation, needed ambulation, needed slowly, and stand for Review of the undar revealed, "At risk (for evealed the resider for transfers, ambul needed assistance repositioning. It revealed the resident oriented disoriented, forgetful demential/Alzheimer deterioration character memory failure). Review of the comprevealed a focus initing the resident had gait and poor balance.	assessment dated 10/13/13 and had a BIMS (Brief Interview core of 6 (severe cognitive aled the resident needed expele for bed mobility, limited for transfers, walking and sident had a fall in last month and in last 2-6 months prior to not experienced falls since CAA (Care Area Assessment) revealed the resident needed assistance from staff for lation, and had moderate risk in tused a walker with to be reminded to get up or a little bit before walking. Ited Admission Care plan for falls) score." It also int needed assist of 1-2 staff ated with 2 person assist, and of 1 for turning and exaled, "Toileting q2hrs (every as needed)." It also revealed dia x 2 (to person and place), all, and had its (progressive mental exercised by confusion and exercised by confusion and exercised the confusion and exercised by confusion and exercised exercised by confusion and exercised exercis	F 23	25		

175532 B. WING 12/19/2	9/2013
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	<i>7.</i> 20.10
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE DEFICIENCY)	(X5) COMPLETION DATE
bathroom. The resident stated he/she was trying to walk without a walker. The record lacked any information on when staff last saw the resident, if the resident needed assistance to get to the bathroom, or supervision in the bathroom, if all other comfort needs were met, or if care plan interventions were followed or still effective in helping to prevent future falls. Review of a nurses note dated 11/2/2013 at 2:09 A.M. revealed the resident continued on fall follow up and complained of pain in the right lower rib area. Staff notified the physician and received an order for a rib X-ray. Review of a Preliminary Report from Radiology Services Corporation revealed 11/2/13 reason as pain after fall 111/113, Findings: Fracture 9th rib. No underlying pleural or parenchymal traumatic/post traumatic changes Review of the Aide Documentation Report for November 2013 revealed, "Tolleting Program (restorative): Take to bathroom every 2 hours during waking hours." During an interview at 1:45 P. M. on 12/12/13, Consultant C reported the charting program and cueing information for staff was not initially set up for individual resident needs. When a resident admitted to the facility, questions/cues like taking to the bathroom every 2 hours were automatically turned on for all residents. Staff C reported the direction did not specify whether staff needed to stay with the resident, or directions not to leave the resident unattended. During an interview at 2:08 P.M. on 12/12/13, Administrative nursing staff B reported he/she did not have any evidence to show an investigation	

		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED	
		175532	B. WING _			C 12/19/2013	
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		12/19/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 225	had been completed assisted the resident had nothing to show the resident unattended of the showing an interview and consultant C reported fracture, but did not have reported to the she/she did not know the incident in, but report called into the state. Review of the facility and Exploitation policy of this facility to as the investigate incidents are resident care. The fact approach for identifying that may constitute all following are exampled 1. Further investigation of the following:Injugundetermined origin; laceration, fracture the not witnessed or specion incident report." It Administrator or their agency and local law suspicion of a crime, event of serious bodil and local police depand Self-reporting of suspineglect to state agence enforcement is mand crime, abuse and neg	to determine whether staff as the resident needed, and that staff did not leave the on the toilet. It 4:43 P.M. on 12/16/13, did the resident received a ave any evidence the injury tate. Consultant C reported why staff did not call the ed the fracture needed to be sundated Abuse, Neglect, y revealed, "It is the policy broughly as possible, affecting all aspects of cility will take a proactive and events or occurrences buse or neglect. The est to be further investigated. In will be conducted for any arry to resident of any marks, bruise, at resident sustains that was cifically reported occurrence also revealed, "The designee will notify the state enforcement of the abuse or neglect. In the y injury, notify both the state retment within 2 hours. ected crime, abuse or cies and local law atory. All other suspicion of glect notify the state agency rtment within 24 hours after	F 2	225			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	COMPLETED	
		175532	B. WING _		C 12/19/2013	
	ROVIDER OR SUPPLIER	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	, 12/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET	TION
F 225	resident had an unw	ensure an incident where a ritnessed fall and sustained a ately reported to the State ion agency.	F 2			
SS=D	ACCURACY/COOR The assessment muresident's status. A registered nurse neach assessment wiparticipation of healt	DINATION/CERTIFIED set accurately reflect the nust conduct or coordinate ith the appropriate th professionals. nust sign and certify that the				
	assessment must sign that portion of the assument must sign that portion of the assument in a subject to a civil more \$1,000 for each assign willfully and knowing to certify a material aresident assessment penalty of not more assessment. Clinical disagreement material and false st	I Medicaid, an individual who ply certifies a material and resident assessment is ney penalty of not more than essment; or an individual who ply causes another individual and false statement in a t is subject to a civil money than \$5,000 for each				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175532	B. WING		C 12/19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	1 12 10 20 10
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPROPRIES OF THE	JLD BE COMPLETION
F 278	Continued From pag	ge 6	F 27	78	
	residents included in residents were revie assessments. Base and record review, t assess the resident's sampled residents.	totaled 52 residents with 7 In the sample. Of those, all 7 It wed for the accuracy of their It on observation, interview It he facility failed to accurately It is fall history for 1 of 7 It is a sample of the sam			
	Findings included:				
	MDS (Minimum Dat 7/24/13 revealed the Interview for Mental cognitive impairmen needed extensive a transfers, walking in locomotion on and of	nt #1's Significant Change a Set) assessment dated be resident had a BIMS (Brief Status) score of 8 (moderate at). It revealed the resident assistance of one person for a room and corridors, off the unit, and had one fall ar injury) since the prior			
	10/10/13 revealed the community (moderate cognitive extensive assistance walking in room and	erly MDS assessment dated ne resident had a BIMS of 10 impairment), and needed e of one person for transfers, corridor, and locomotion on assessment revealed the s since the previous			
	MDS revealed the rechange in mental st assessment, and had difficulty with oriental and some short term maintained convers	7/24/13 Significant Change esident demonstrated a			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		175532	B. WING			C 12/19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	Continued From page	ge 7	F 27	78		
	had a change in AD	so revealed, "Resident has L (activities of daily living) more help since last				
	MDS revealed the rebruising. The reside diuretics as well as an antidepressant. Trange of motion to ha 1 person assist. Trand walker for ambu	e 7/24/13 Significant Change esident had an actual fall with nt had medication orders for narcotic pain medication and The resident has restricted is/her shoulder, and was also he resident used a gait belt ulation with assistance of 1 ADL score had declined as				
	well as his/her BIMS	S since the last assessment. t 2:51 A.M. revealed the				
	resident experience slid off the edge of h noted, and no comp re-educated the res using the call bell fo acknowledged under	d a fall that shift. The resident his/her bed, had no injuries laints of pain voiced. Staff ident on the importance of r all needs. The resident erstanding of the teaching, and ted to check on the resident				
	8:15 A.M. a nurse a resident was on the room and found the the closet doorway knees bent. The resident reported in the bottom of the wheelchair were set the resident's reach	o13 at 9:35 A.M. revealed, at ide notified the writer that the floor. The write entered the resident on the floor just in ying on his/her left side with sident complained of pain at a being the worst) to the left oftion could not be performed. The walker and veral feet away and not within the nurse aide last checked A.M. The writer notified the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175532	B. WING		C 12/19/2013
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	1 12/13/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 279 SS=E	the resident lay in be reported he/she remension his/her hip, but did not was doing just prior to buring an interview and Administrative Nursing resident's falls from Sushow up on the elect did not get coded on the MDS should have resident experienced. Review of the facility Data Set) policy reversidently a compression of the facility that each facility failed to hassessment that according resident's fall history. 483.20(d), 483.20(k), COMPREHENSIVE of the facility must use the facility must use the facility must develop, review and comprehensive plan. The facility must develop for each resident	the resident to the further assessment. P.M. on 12/11/13 revealed d. At that time, the resident embered falling and breaking of remember what he/she to the fall. at 3:33 P.M. on 12/16/13, and staff K reported the b/23/13 and 9/10/13 did not ronic fall tracking list so they the MDS. Staff K reported electrified the two falls the before that time. It is undated MDS (Minimum staled it is the policy of the ity will conduct initially and enensive, accurate, ucible assessment of each capacity. In ave a quarterly MDS curately reflected the conduct of the assessment of each capacity. It is the policy of the ity will conduct initially and enensive, accurate, ucible assessment of each capacity. In ave a quarterly MDS curately reflected the conduct of the assessment of eresults of the assessment of eresults of the assessment and revise the resident's	F 27		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		175532	B. WING _			C 12/19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT F	REEDS COVE	1	STREET ADDRESS, CITY, STATE, ZIP CO 2114 N 127TH CT EAST WICHITA, KS 67228	DDE	12/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA	
F 279	assessment. The care plan must of to be furnished to atta highest practicable pipsychosocial well-bei §483.25; and any serbe required under §4 due to the resident's §483.10, including th under §483.10(b)(4). This REQUIREMENT by: The facility census to residents included in residents were review plans. Based on obserecord review, the factomprehensive care residents regarding fadily living). (#1, #3, Findings included: Review of resident MDS (Minimum Data 7/24/13 revealed the Interview for Mental Scognitive impairment needed extensive as walking in room and off the unit, and had on injury) since the prior Review of the Quarter	lescribe the services that are ain or maintain the resident's hysical, mental, and ing as required under vices that would otherwise 83.25 but are not provided exercise of rights under e right to refuse treatment I is not met as evidenced otaled 52 residents with 7 the sample. Of those, 7 wed for comprehensive care ervation, interview and cility failed to have a plan for 5 of 7 sampled alls and ADLs (activities of #4, #6, #7,) It #1's Significant Change Set) assessment dated resident had a BIMS (Brief Status) score of 8 (moderate of the resident sistance of one for transfers, corridors, locomotion on and one fall with injury (not major	F2	279		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		175532	B. WING		,	C 2/19/2013
	ROVIDER OR SUPPLIER	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	<u>'</u>	2110/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	Continued From page	ge 10	F 27	79		
	extensive assistance walking in room and					
	Assessment) for the MDS revealed the rechange in mental stand had demonstrat orientation in regard short term memory. conversation, answeunderstood others a also revealed, "Resi	7/24/13 Significant Change esident demonstrated a latus since last assessment, ed some difficulty with s to time/date and some. The resident maintained ered questions appropriately, and could be understood. It dent has had a change in illy living) scores and requires				
	MDS revealed the rebruising. The resider diuretics as well as an an antidepressant. Trange of motion to ha 1 person assist. The and walker for amburperson, and his/her.	e 7/24/13 Significant Change esident had an actual fall with inthe had medication orders for narcotic pain medication and The resident has restricted is/her shoulder, and was also ne resident used a gait belt elation with assistance of 1 ADL score had declined as a since the last assessment.				
	resident experienced resident had an alter musculoskeletal state knee after an unwith care plan had intervention with the use of supp	plan in place prior to a fall the d on 11/17/13 revealed the ration in his/her tus related to pain in the right lessed fall on 7/17/13. The entions to assist the resident ortive devices (wheelchair, anded), follow physician orders				

C
12/19/2013
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RECTION (X5) SHOULD BE COMPLETION PPROPRIATE DATE
5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175532	B. WING		C 12/19/2013	
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
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F 279	Continued From pag	ge 12	F 27	9		
	the resident lay in be reported he/she rem his/her hip, but did r was doing just prior reported he/she need get around most of the get ar	at 2:55 P.M. on 12/11/13, and Direct Care staff F both fall on 11/17/13, the resident room independently, the bathroom and walking out corted the resident would call sistance, and staff F reported the resident had increased the resident walked well and a staff F reported the resident walked well and the resident walked well and the resident walked well and purpose of the care plan was to care for the resident. The sundated Comprehensive realed, "3. Each resident's ividualized and will reflect the posocial issues/concerns and the particular resident." The sundated Comprehensive fall the entregarding his/her history, and interventions to help				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	
F 279	P/30/2013 revealed to Review of the Admis Set) assessment data resident had a BIMS Status) score of 6 (so It revealed the reside people for bed mobil for transfers, walking resident had a fall in admission, and in last admission, but had readmission. Review of the Fall Confor Admission MDS in limited to extensive a transfers and ambulation, needed slowly, and stand for Review of the undata revealed, "At risk (for revealed the resident for transfers, ambulation needed assistance or repositioning. It reve 2 hours) and PRN (at the resident oriented disoriented, forgetful dementia/Alzheimer'deterioration charact memory failure). Review of the comprisor 10/10/13) revealed it	sion Assessment dated he resident at risk for falls. sion MDS (Minimum Data ed 10/13/13 revealed the (Brief Interview for Mental evere cognitive impairment). Ent needed limited assist of 2 ity, limited assist of 1 person and locomotion. The last month prior to st 2-6 months prior to sot experienced falls since AA (Care Area Assessment) evealed the resident needed assistance from staff for ation, and had moderate risk to used a walker with to be reminded to get up a little bit before walking. Ad Admission Care plan falls) score." It also to needed assist of 1-2 staff ted with 2 person assist, and for turning and aled, "Toileting q2hrs (every s needed)." It also revealed x 2 (person and place),	F2	279		

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F 279	Continued From pag	e 14	F 27	79	
	resident needed with experienced a fall or the resident had an a and poor balance.	clude the assistance the daily cares until the resident 11/1/13 when it staff added actual fall and unsteady gait			
	Direct Care staff J, h at risk for falls, and u for ambulation and tr same day, staff J rep the room if the reside restroom because th without calling for he	et 12:40 P.M. on 12/12/13 e/she reported the resident used a walker with a gait belt transfers. At 1:31 P.M. that borted staff needed to stay in ent needed extra time in the e resident would get up lp. Staff J reported the d to know to call for help.			
	staff K reported the of the resident's care no included the resident	6/13, Administrative Nursing care plan needed to include eeds, any issues and t's input. Staff K reported the lift how to care for the			
	Care Plan policy revo	's undated Comprehensive ealed, "3. Each resident's vidualized and will reflect the social issues/concerns and particular resident."			
		nave a comprehensive care ner fall risk and ADL needs.			
		#4's electronic record face esident admitted to the facility			
	Set) assessment dat	sion MDS (Minimum Data ed 9/20/13 revealed the (Brief Interview Mental			

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	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	1 12/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 279	extensive assistance transfers, locomotion assistance of 1 for withe unit. The resident prior to admission, and admission. Review of the Fall Conformer of the 9/20/13 Admission. Review of the Fall Conformer of the 9/20/13 Admission. Review of the Fall Conformer of the 9/20/13 Admission. The resident home time, without injusted the chair to the bedical light within react provided education revealed the resident received medication falls. Review of the the And 9/21/13 (not initiated resident admitted to resident admitted to resident at risk for fall program of every 2 request, needed assist of one person	(cognitively intact), needed e of 1 for bed mobility, n off unit, needed limited valking, and locomotion on nt had no falls in the 6 months and had 1 non-injury fall since CAA (Care Area Assessment) ission MDS revealed the	F 27	,	
	revealed, (initiated of confusion, it directed each time in the res to use the call light to care plan did not income	ent's comprehensive care plan on 10/5/13) due to increased d staff to remind the resident ident's room for the resident to call for assistance. The clude the resident's fall risk, ventions, or ADL (activities of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		175532	B. WING _			C 1 2/19/2013	
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		12/19/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 279	Continued From page daily living) needs a 10/9/13. A note on 9/16/13 3 resident walked unsthe resident did not Staff re-educated the when in need of help low position and the Another note on 9/1 "Fall follow up- No in noted, chronic pain remind res. (resident A note 9/19/13 at 8: performed a head to resident, assessed motion, and reveale injuries. Staff notifies physician, and family resident on the imposystem and not getted. A nurses note on 9/2 the resident fell at 1 he/she was trying to balance. The reside but did receive a skill.	,	F 2	DEFICIE			
	A note on 10/9/13 at P.M., someone foun The resident was also complained of pain it resident said it "just"						

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	FIPLE CONSTRUCTION NG	1, ,	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)			175532	B. WING _			_	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			REEDS COVE		2114 N 127TH CT EAST		113/2013	
F 279 Continued From page 17 F 279	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
During an interview with Direct Care staff J at 12:40 P.M. on 12/12/13, he/she reported he/she remembered the resident had a bed pad alarm at one point, and had a few falls tripping over the resident's oxygen cord. Staff J reported he/she had to make sure the oxygen tubing was not in the resident's way when staff helped the resident to the bathroom. Staff J reported he/she thought the resident and the most trouble with following directions and stability just after waking up in the morning, but after that, the resident acted fine the rest of the day. The resident needed assistance from one staff member, and used a gait belt and walker for locomotion. At 11:47 A.M. on 12/12/13, Licensed Nursing staff G reported the resident a very big fall risk. The resident had the physical ability to do things and the mental ability to do it, but staff G reported the resident had problems with his/her oxygen level when he/she stood up. Staff G reported he/she expected aides to check on the resident about every 2 hours due to his/her history of falls. When the resident first admitted to the facility, the resident middle and ask for assistance, but as time progressed, the resident needed more cueing and reminding to complete daily tasks. At 3:35 P.M. on 12/16/13, Administrative Nursing staff K reported the purpose of the care plan was to tell the staff how to care for the resident. Review of the facility's undated Comprehensive Care Plan policy revealed, "3. Each resident's care plan will be individualized and will reflect the physical and psychosocial issues/concerns and interventions for that particular resident."	F 279	During an interview 12:40 P.M. on 12/12 remembered the resone point, and had resident's oxygen chad to make sure the resident's way to the bathroom. Stathe resident had the directions and stabinorning, but after the rest of the day. The from one staff mem walker for locomotion of the day. The from one staff mem walker for locomotion of the day. The from one staff mem walker for locomotion of the day. The from one staff mem walker for locomotion of the mental ability to resident had the phase the mental ability to resident had proble when he/she stood expected aides to devery 2 hours due to the resident first addresident would call at time progressed, the cueing and reminding the staff K reported the to tell the staff how Review of the facility Care Plan policy recare plan will be incophysical and psychological staff of the staff of the physical and psychological staff of the s	with Direct Care staff J at 2/13, he/she reported he/she sident had a bed pad alarm at a few falls tripping over the ord. Staff J reported he/she he oxygen tubing was not in when staff helped the resident aff J reported he/she thought e most trouble with following lity just after waking up in the nat, the resident acted fine the resident needed assistance ber, and used a gait belt and on. 2/12/13, Licensed Nursing staff dent a very big fall risk. The ysical ability to do things and do it, but staff G reported the ms with his/her oxygen level up. Staff G reported he/she heck on the resident about o his/her history of falls. When mitted to the facility, the and ask for assistance, but as a resident needed more ng to complete daily tasks. 16/13, Administrative Nursing purpose of the care plan was to care for the resident. y's undated Comprehensive wealed, "3. Each resident's lividualized and will reflect the osocial issues/concerns and	F2	279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		175532	B. WING		4.	C 2/19/2013	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2114 N 127TH CT EAST WICHITA, KS 67228		2/19/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 279	Continued From pag	ge 18	F 27	79			
	plan that reflected the interventions directing for falls, or the resident assessment dated 1 had a BIMS of 15 (conseded extensive assessing, and toilet ulimited assistance of corridor, locomotion hygiene. The resident for falls, and to the corridor of the resident falls.	have a comprehensive care he resident's high fall risk, and staff how to reduce the risk ent's ADL abilities and needs. It #7's Admission MDS 1/26/13 revealed the resident ognitively intact). The resident ossistance of 2 people for bed valking in his/her room, use. The resident needed fone for walking in the on/off the unit, and personal int needed supervision and g, had no falls prior to admission.					
	revealed, alert and of incontinent care and of 1 for transfers, us assistive walking de mobility, assist of on assist of one for turn received routine and medications, and was carbohydrate diet. Review of the reside plan initiated 11/28/planned to remain in (Physical Therapy) service), had an OT clarification order (we medical history of de interventions. The recare plan, with listed warnings. The care	I to take to bathroom, assist ed a cane/quad (type of vice) and wheelchair for the with grooming and bathing, ning and repositioning, I PRN (as needed) pain the diabetic with a controlled ent's Comprehensive care 13 revealed the resident the facility. Received PT the facility is revealed in the facility is revealed in the facility. Received PT the facility is revealed in the facility is revealed in the facility is revealed in the facility. Received PT the facility is revealed in the facility is revealed in the facility is revealed in the facility. Received PT the facility is revealed in the facility is revealed					

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		175532	B. WING			C 12/19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	Continued From page	ge 19	F 2	79		
		eds, activity wants and needs, nt needed assistance with				
	Direct Care staff L re extensive assistance remote controlled w around independent tallied the residents urinal for his/her out did not think the result not need assistance L reported he/she w	at 11:00 A.M. on 12/16/13, eported the resident needed e with dressing, but had a heelchair and could get tly. Staff L reported staff intake and output, and used a cput. Staff L reported he/she ident was a diabetic, and did with eating or hygiene. Staff rould look at the care plan questions about a resident's				
	the resident reclined watched television. planned to stay livin	4 A.M. on 12/16/13 revealed in a recliner chair, and The resident reported he/she g in the facility, and reported stance with most of his/her				
	staff K reported the	16/13, Administrative Nursing purpose of the care plan was to care for the resident.				
	staff B and Consulta	16/13, Administrative Nursing ant C reviewed the resident's ted the care plan did not ldress the resident's care				
	Care Plan policy rev care plan will be ind physical and psycho	y's undated Comprehensive realed, "3. Each resident's ividualized and will reflect the psocial issues/concerns and t particular resident."				

		A. BUILDING	i	COMPLETED
	175532	B. WING		C 12/19/2013
ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	, 12:10/2010
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
Continued From page	ge 20	F 27	9	
plan for a resident rediabetic, dietary and Review of resider revealed the resider 9/12/13. Review of the Admi Set) assessment daresident had no diffirmemory, needed lin member for bed motransfers, walking in and limited assistant corridor, and locomorthe resident experito admission, staff with the resident had a fradmission or if the refracture in that time Review of the Fall Correction for the admission of the resident admitted care and was post pelvis) fracture. The weeks prior to admiphysical. The resider a history of a total kenguired extensive a members for many	egarding his/her ADL, fall risk, d activity needs. In #6's electronic Face Sheet in admitted to the facility on ssion MDS (Minimum Data atted 9/19/13 revealed the iculty with short and long term inited assistance of 1 staff (bility, extensive of 2 staff for a room and locomotion on unit, ince of 2 staff for walking in otion off the unit did not occur. enced a fall in last month prior were unable to determine if all in the 2-6 months prior to resident experienced a . No falls since admission. CAA (Care Area Assessment) IDS dated 9/19/13 revealed at to the facility for long term obtain the prior to resident had a fall about 2 since per the history and ent had chronic knee pain with nee replacement, and assistance of 1-2 staff ADLs (activities of daily			
living). The resident needed" pain medic at times.	took scheduled and "as cation, and incontinent of urine ted temporary care plan			
	SUMMARY S (EACH DEFICIENT REGULATORY OF RESIDENT OF RESIDENT OF RESIDENT OF RESIDENT OF RESIDENT OF REGULATORY OF	ALTH AND REHAB AT REEDS COVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 The facility failed to have a comprehensive care plan for a resident regarding his/her ADL, fall risk, diabetic, dietary and activity needs. - Review of resident #6's electronic Face Sheet revealed the resident admitted to the facility on 9/12/13. Review of the Admission MDS (Minimum Data Set) assessment dated 9/19/13 revealed the resident had no difficulty with short and long term memory, needed limited assistance of 1 staff member for bed mobility, extensive of 2 staff for transfers, walking in room and locomotion on unit, and limited assistance of 2 staff for walking in corridor, and locomotion off the unit did not occur. The resident experienced a fall in last month prior to admission, staff were unable to determine if the resident had a fall in the 2-6 months prior to admission or if the resident experienced a fracture in that time. No falls since admission. Review of the Fall CAA (Care Area Assessment) for the admission MDS dated 9/19/13 revealed the resident admitted to the facility for long term care and was post pubic rami (a part of the pelvis) fracture. The resident had a fall about 2 weeks prior to admission per the history and physical. The resident had chronic knee pain with a history of a total knee replacement, and required extensive assistance of 1-2 staff members for many ADLs (activities of daily living). The resident took scheduled and "as needed" pain medication, and incontinent of urine	ALTH AND REHAB AT REEDS COVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 F 27 The facility failed to have a comprehensive care plan for a resident regarding his/her ADL, fall risk, diabetic, dietary and activity needs. - Review of resident #6's electronic Face Sheet revealed the resident admitted to the facility on 9/12/13. Review of the Admission MDS (Minimum Data Set) assessment dated 9/19/13 revealed the resident had no difficulty with short and long term memory, needed limited assistance of 1 staff member for bed mobility, extensive of 2 staff for transfers, walking in room and locomotion on unit, and limited assistance of 2 staff for walking in corridor, and locomotion off the unit did not occur. The resident experienced a fall in last month prior to admission, staff were unable to determine if the resident had a fall in the 2-6 months prior to admission or if the resident experienced a fracture in that time. No falls since admission. Review of the Fall CAA (Care Area Assessment) for the admission MDS dated 9/19/13 revealed the resident admitted to the facility for long term care and was post pubic rami (a part of the pelvis) fracture. The resident had a fall about 2 weeks prior to admission per the history and physical. The resident had chronic knee pain with a history of a total knee replacement, and required extensive assistance of 1-2 staff members for many ADLs (activities of daily living). The resident took scheduled and "as needed" pain medication, and incontinent of urine at times. Review of the undated temporary care plan	ALTH AND REHAB AT REEDS COVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 The facility failed to have a comprehensive care plan for a resident regarding his/her ADL, fall risk, diabetic, dietary and activity needs. - Review of resident #6's electronic Face Sheet revealed the resident admitted to the facility on 9/12/13. Review of the Admission MDS (Minimum Data Set) assessment dated 9/19/13 revealed the resident had no difficulty with short and long term memory, needed limited assistance of 1 staff member for bed mobility, extensive of 2 staff for transfers, walking in room and locomotion on unit, and limited assistance of 2 staff for walking in corridor, and locomotion off the unit did not occur. The resident experienced a fall in last month prior to admission, staff were unable to determine if the resident had a fall in the 2-6 months prior to admission or if the resident experienced a fracture in that time. No falls since admission. Review of the Fall CAA (Care Area Assessment) for the admission MDS dated 9/19/13 revealed the resident admitted to the facility for long term care and was post pubic ramin (a part of the pelvis) fracture. The resident had a fall about 2 weeks prior to admission per the history and physical. The resident dornoic knee pain with a history of a total knee replacement, and required extensive assistance of 1-2 staff members for many ADLs (activities of daily living). The resident took scheduled and "as needed" pain medication, and incontinent of urine at times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175532	B. WING		C 12/1	9/2013
	ROVIDER OR SUPPLIER	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	12/1	3/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	staff for transfers, use ambulated with assist at risk for falls, and no person for repositionic Review of the resider (to be completed at the admission) revealed fall with no injury relable balance, poor commu (initiated on 11/14/13 revealed the resident with even floors free reachable call light, the night; slide fails as or walls, personal items 12/5/13), Be sure call encourage to use it for Needs prompt respond assistance (12/5/13). (specify) times daily (interventions on the at 12/5/13). For no app and address causative 12/5/13). The compression of the resident's finterventions in place falls until after the resident's finterventions in place falls until after the resident's fall	athroom, assistance of 1 ed a walker and wheelchair, t of one and a gait belt, was eeded assistance of 1 ng. nt's comprehensive care plan he latest, 21 days after the resident had an actual ted to unsteady gait, poor unication/comprehension and revised on 12/5/13). It needed a "safe environment from spills and/or clutter; light, a working and he bed in low position at dered, handrails on the within reach (initiated on light is within reach and or assistance as needed. hase to all requests for Check range of motion initiated 12/5/13). Continue	F 27	,		
	staff. Review of a nurses n P.M. revealed staff fo the floor. The residen attempting to go to th					

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		175532	B. WING _			C 2/19/2013	
	ROVIDER OR SUPPLIER	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CO 2114 N 127TH CT EAST WICHITA, KS 67228		12/19/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 279	difficulty or discomfor instructed the resider attempt to transfer him. Observation at 2:20 Fithe resident stood new held onto a walker. It is applied a gait belt to members held the garesident as they pulled. The staff members we resident's pace as the the perimeter of the him to fall. The resident resome things on his/he/she got help for.	all extremities without any t, and had no injuries. Staff int to ask for help and not mself/herself. P.M. on 12/11/13 revealed xt to Direct Care staff F and Direct Care M walked over, the resident and the two staff it belt and walked with the ed the wheelchair behind. alked slowly and at the e resident ambulated around house. t 3:20 P.M. on 12/11/13, the she remembered he/she had member what caused him/her eported he/she could do er own and some things	F 2	7.79			
F 281	staff K reported the p tell the staff how to ca Review of the facility! Care Plan policy reve care plan will be indiv physical and psychos interventions for that The facility failed to h plan for a resident re- history of falls, interver resident's risk for falls abilities.	s undated Comprehensive caled, "3. Each resident's vidualized and will reflect the cocial issues/concerns and particular resident." ave a comprehensive care garding his/her fall risk,	F 2	81			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMP	SURVEY LETED	
		175532	B. WING				C 19/2013
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	19/2013
AVITA HE	ALTH AND REHAB AT R	EEDS COVE			2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281 SS=D			F:	281			
	by: The facility census to residents included in residents were review plans. Based on obserecord review, the fac	plan on admission for 2 of 7					
	sheet revealed the re on 9/14/13.	#4's electronic record face sident admitted to the facility					
	9/21/13 (not initiated resident admitted to t resident at risk for fal program of every 2 he request, needed assistransfers, used a wall assist of one person. was alert, forgetful, recare/noncompliant. T	he facility) revealed the ls. It revealed a toileting ours and at the resident's stance of 1 person for ker and ambulated with It also revealed the resident					
	P.M. revealed the resassistance of 1 staff r	oted dated 9/15/13 at 1:32 ident needed supervised nember with all ADLs ng) and transfers, and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		175532	B. WING			C 12/19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	<u> </u>	12/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 281	Continued From pag		F 28	31		
	resident very unstea himself/herself. The	resident had no admission aff on how to assist the				
	resident walked uns the resident did not Staff re-educated the when in need of help low position and the resident had no adm	34 A.M. also revealed the teady to the bathroom, and use the call light all the time. It is resident to use the call light of the resident's bed was in call light within reach. The hission care plan to address for re-education to use the ce from staff.				
	"Fall follow up- No ir noted, chronic pain of remind res. (residen The resident had no	9/13 at 11:09 A.M. revealed, njuries notes- No acute pain continues, Cont (continue) to t) to ask/wait for assistance." admission care plan to t's increased fall risk, or a fall need in the facility.				
	an admission care p the day of admission Consultant C reporte	ed there had been a lot of ration and that may have				
		6/13, Administrative Nursing care plan told the staff how to				
	After requests, the faregarding admission	acility did not provide a policy care plans.				
	The facility failed to	have a care plan on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		175532	B. WING			C 1 2/19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT			STREET ADDRESS, CITY, STATE, ZIP COD 2114 N 127TH CT EAST WICHITA, KS 67228		12/19/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	revealed the resider 9/12/13. Review of the Admisset) assessment daresident had good so needed limited assist mobility, extensive of in room and locomo assistance of 2 staff locomotion off the unexperienced a fall in admission, staff were resident had a fall in admission or if the resident had a fall in admission or if the resident had a fall in admission or if the resident had a fall in admission or if the resident admitted care and was post pelvis) fracture. The weeks prior to admit physical. The resider a history of a total kneeding history of a total kneeding. The resident needed" pain medicat times. Review of the undaresider of the undaresider of the undaresider of the undaresider.	ent #4. It #6's electronic Face Sheet and admitted to the facility on sesion MDS (Minimum Data and 9/19/13 revealed the short and long term memory, estance of 1 staff for bed of 2 staff for transfers, walking attention on unit, and limited a for walking in corridor, and an it did not occur. The resident an last month prior to be unable to determine if the an the 2-6 months prior to be esident experienced a and No falls since admission. CAA (Care Area Assessment) DS dated 9/19/13 revealed and to the facility for long term outsic rami (a part of the experience pain with a fall about 2 sesion per the history and ent had chronic knee pain with the experience of 1-2 staff and assistance of 1-2 staff and a scation, and incontinent of urine atted temporary care plan	F 2	81		
	revealed the resider hours to the bathroo 1 staff for transfers,	nt needed prompting every 2 om for toileting, assistance of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		175532	B. WING _			C 12/19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	'	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 281	Continued From pag	ge 26	F 2	81		
	of 1 person for repo- not reflect the fall the 9/15/13. Review of a nurses P.M. revealed staff the floor. The reside attempting to go to thimself/herself and resident could move difficulty or discomfor instructed the reside attempt to transfer helacked any indication investigation after the	he bathroom by missed some steps. The e all extremities without any ort, and had no injuries. Staff ent to ask for help and not nimself/herself. The record n staff completed an ne fall to ensure staff provided				
	effective. Observation at 2:20 the resident stood n held onto a walker. applied a gait belt to members held the gresident as they pull The staff members we resident's pace as the perimeter of the During an interview	P.M. on 12/11/13 revealed ext to Direct Care staff F and Direct Care M walked over, the resident and the two staff ait belt and walked with the led the wheelchair behind. Walked slowly and at the ne resident ambulated around				
	fallen, but did not re to fall. The resident some things on his/I he/she got help for.	member what caused him/her reported he/she could do ner own and some things				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		175532	B. WING		C 12/19/2013	
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 281	Continued From pag	ge 27	F 28	31		
	staff K reported the care for the resident	care plan told the staff how to				
	After requests, the faregarding admission	acility did not provide a policy a care plans.				
F 323 SS=H	resident's admission experienced a fall 3 483.25(h) FREE OF HAZARDS/SUPER\ The facility must ensenvironment remain		F 32	23		
	1	n and assistance devices to				
	by: The facility census is residents included in residents (including reviewed for accider interview and record ensure that each resident resident as free from possible and each resident interview and record ensure that each resident resident in the failure to attempt to determine failed to review the conew/effective interversion in the failure to investigate the failure to investigate in the failure in the	totaled 52 residents with 7 in the sample. Of those, 6 3 closed records) were ints. Based on observation, I review, the facility failed to sident's environment am accident hazards as esident received adequate istance devices to prevent investigate each fall to be the cause of the fall and care plan and implement entions to prevent further falls. It is gate falls and implement in seculted in 4 residents				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		175532	B. WING			C 2/19/2013	
	ROVIDER OR SUPPLIER ALTH AND REHAB AT		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228			12/19/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	#5 and #6) Findings included: Review of resider orders sheet dated following diagnoses: osteoarthrosis involve of chronic arthritis we (swelling resulting fr accumulation of fluid specified rehabilitation weakness (generalize lymphedema (swelling lymph). The resident's signift Data Set) assessmeresident had a BIMS Status) score of 8 (not impairment). It reveated extensive assistance walking in room and off the unit, and had injury) since the priority of the quarter 10/10/13 revealed the funderate cognitive extensive assistance walking in room and and off the unit. The resident had no falls	after falling. (#1, #2, #3, #4, #1's signed physician's #1/27/13 revealed the difficulty in walking, general ving multiple sites (condition ithout inflammation), edema om an excessive in the body tissues), other on procedure, muscle ed), and noninfectious in graused by accumulation of dicant change MDS (Minimum and dated 7/24/13 revealed the signer of transfers, corridors, locomotion on and one fall with injury (not major or assessment. Berly MDS assessment dated the resident had a BIMS of 10 impairment) and needed the resident had a BIMS of 10 impairment) and needed the since the previous sessment failed to include 2 perienced during the me.	F 33	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		175532	B. WING		C 12/19/2013	
	ROVIDER OR SUPPLIER ALTH AND REHAB AT			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	12/19/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 323	demonstrated a chathe last assessment some difficulty with time/date and some resident maintained questions appropriated and could be under resident has had a daily living) abilities the last assessment. The Fall CAA dated had an actual fall we restricted range of resident had an actual fall we restricted range of resident assessment. Review of the resident dated 5/12/13 reveated for the care resident experience resident had an alternative after an unwith (initiated on 7/17/13 interventions to assess supportive devices recommended), foll bearing status, and and monitor and do effectiveness. The cresident had limited resident had limited and limited the some some supportive devices recommended.	7/24/13 revealed the resident ange in mental status since to the short term memory. The conversation, answered ately, and understood others astood. It also revealed the change in ADL (activities of and required more help since to the short term memory. The conversation, answered ately, and understood others astood. It also revealed the change in ADL (activities of and required more help since to the short term memory. The resident had motion to his/her shoulder and a sasist. The resident used a for ambulation with son and his/her ADL abilities all as his/her BIMS since the sent's fall risk assessment alled the resident with a score in risk for falls.	F 32	3		

STATEMENT OF I AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII		ONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		175532	B. WING					C 19/2013
	/IDER OR SUPPLIER	REEDS COVE		211	EET ADDRESS, CITY, STATE, ZIP CODE 4 N 127TH CT EAST CHITA, KS 67228		12/	13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE		(X5) COMPLETION DATE
w m an no recent factor of the control of the contr	conitor for signs and and provide therapy bedded. The care plesident's high risk for experienced the fall deeded follow to help alls, or updates after experienced. Increase note on 7/1 aff found the reside form crying, stating, and fell on the floor." tals and identified a sident's knee, tend esident winced/whire tempted to straight the assessment, assent and an of care to ensure urses' note on 9/10 esident experienced id off the edge of he oted, and no complete educated the resident and the record lacked every endicated the resident experienced id off the edge of he oted, and no complete educated the resident experienced id off the edge of he oted, and no complete educated the resident experienced in the edge of he oted, and no complete educated the resident experienced in the edge of he oted, and no complete educated the resident experienced in the edge of he oted, and no complete educated the plan of officitive.	e 30 n, and directed staff to d symptoms of immobility, referrals as ordered and as an did not include the or falls after the resident on 7/17/17, interventions staff or reduce the risk for further reach fall the resident 7/13 at 9:37 A.M. revealed ent on the toilet in his/her "I couldn't make it and I wet Staff took the resident's a fresh bruise to the ler to the touch, and the inpered when he/she en his/her leg. Staff finished disted the resident from the d the physician and family. vidence staff reassessed the reviewed or updated the e it remained effective. 7/13 at 2:51 A.M. revealed the I a fall that shift. The resident is/her bed, had no injuries aints of pain voiced. Staff dent on the importance of all needs. The resident restanding of the teaching, and ed to check on the resident restanding of the teaching, and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident restanding of the teaching and ed to check on the resident	F	323				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		175532	B. WING		C 12/19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	12.10.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 323	writer entered the rotthe floor just in the of left side with knees complained of pain being the worst) to motion could not be reported he/she rea of the closet. The w several feet away a reach. The nurse ai 7:15 A.M. The write sent the resident to further assessment revealed the resident without injury. Staff resident's status and the care plan after thospital to ensure the effective. Review of a note da revealed the resident assistance with toile with his/her wheelof. A nurse's note on 1 the resident on the end toward the entroward the entroward the recliner. from the wall, the way away from the resident to he/she just go and fell when trying lost balance. "My leand left shoulder humand the left shoulder humand the left shoulder humand the left shoulder humand left shoulder humand the left shoulder humand left shoulder left shoulder humand left shoulder	ent was on the floor. The com and found the resident on closet doorway lying on his/her bent. The resident at a 10 (1 to 10 scale, 10 the left hip, and range of performed. The resident ched for clothes in the bottom alker and wheelchair were and not within the resident's de last checked on resident at a notified the APRN, and staff the emergency room for Further review of the record at returned to the facility failed to reassess the diffield to review and update the resident returned from the me interventions were	F 32		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		175532	B. WING		C 12/19/2013	
	ROVIDER OR SUPPLIER	REEDS COVE	2	TREET ADDRESS, CITY, STATE, ZIP CODE 114 N 127TH CT EAST VICHITA, KS 67228	12.10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 323	left cheek, and was a place and time, but we resident described the left leg, upper back a Nursing staff called (EMS) along with all placed a pillow understayed with him/her EMS left the building 5:00 P.M. to head to of the hospital visit releft hip fracture. Observation at 2:18 the resident lay in behis/her call light with resident reported hebreaking his/her hip, he/she was doing juresident reported hehim/her get around in 12/12/13 at 11:43 A. he/she did not remein prior. During an interview are ported, before the ambulated in his/her including going to the to meals. Staff E rep if he/she needed asshe/she did not think risk for falls because was not unsteady. During an interview and time the place of	alert and oriented to person, was slightly confused. The ne pain location to the hips, and left shoulder blade. Emergency medical services other needed contacts, or the resident's head and until the ambulance arrived. It was the resident around ward the hospital. The results evealed the resident had a several with a blanket and in reach. At that time, the step income to the fall. The step income of the time. On M., the resident reported mber being visited the day at 2:55 P.M. on 12/11/13, and Direct Care staff F both fall on 11/17/13, the resident room independently, the bathroom and walking out the resident would call sistance, and staff F reported the resident walked well and the resident the resident lls prior to the fall on 12/12/13, aff G reported the resident lls prior to the fall on	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		175532	B. WING			C 12/49/2043	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	12/19/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	11/17/13. Staff G rep walker, and needed time the resident was bathroom or to the connection on 11/17/13, the resight table with item by. Staff G reported items, and staff need things were within resultings an interview Administrative nursing did not have any investigated an appropriate interventials. During an interview Physician H reported where the resident essent to the emergen no major injuries. The 11/17/13 and did sure the resident experience follow the care plan. The facility failed to help determine any resident's care to he The resident experience in the resident exp	corted the resident used a supervised assistance every s up, walked, went to the ining room. Up until the fall ident had a bed side and is he/she liked to have close the resident utilized those ded to make sure those each. at 6:00 P.M. on 12/12/13, and staff C reported the facility estigations from the multiple he resident experienced on corted the falls should have and the care plan updated with tions to help prevent future at 10:00 A.M. on 12/16/13, and the resident did have a fall experienced hip pain, was constain a hip fracture. Physician expected staff to investigate ings could be done differently er falls. Physician H reported int every fall, but did need to	F3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		175532	B. WING _		,	C 12/19/2013	
	ROVIDER OR SUPPLIER	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	- '	12/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	rehabilitation proced (rapid, irregular head Review of the admiss Data Set) assessmeresident had short a impairment, needed people for transfers, needed extensive as mobility, and locomoresident did have a dadmission, but had admission. Review of the Cogni (Care Area Assessmerevealed the resider CVA (cerebrovascul death of brain cells of the blood flow to the blockage or rupture and ischemic stroke resident to have shown memory deficits, and The resident had dis date, and currently rementia. The CAA recent hospitalization become worse as he seizures and a stead the hospitalization, the neurological deficits resident's continence.	g diagnoses: other specified ure and atrial fribrillation	F 3.	23			
		AA for the 5/30/13 MDS It had a potential for falls.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		175532	B. WING		1:	C 2/ 19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE	21	TREET ADDRESS, CITY, STATE, ZIP CODE 14 N 127TH CT EAST ICHITA, KS 67228		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	and had a new onse got anxious and atte. The resident had all required extensive a ambulation. Review of the reside dated 5/24/13 reveated falls. The resident had all resident had all required extensive a falls. The resident had real alarm, oriented demential Alzheimel use simple short coincontinent care for toileting schedule eneeded assistance repositioning and an a wheelchair for more a wheelchair for more sident was at risk during the resident's risk related to confur hearing problems, a linterventions initiated direction to staff to a ambulation, bed ala each time the resident sit in the activity when awake activity to redirect a therapy to evaluate gait belt each time to	y of falling prior to admission et of seizures. The resident empted to get up unattended. arms for prevention, and assistance for transfers and ent's admission care plan aled the resident at risk for ad a low bed, bed and/or d to self, alert, and had et's. The plan directed staff to mmands, the resident needed bowel and bladder, had a very 2 hours, and the resident of 1 for transfers, mbulation. The resident used	F 323			
	requested to use the toileting program, a	uded the resident frequently e bathroom, had a restorative nd while awake it directed sident to the bathroom every				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED		
		175532	B. WING		C	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		12/19/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 323	bed to the lowest por provide a group or i attention from trying. The record also included detection from from trying. The record also included detection from from trying. The record also included detection from from from from from from from from	ge 36 esident was in bed, set the osition, and when restless, individual activity to divert it to stand unattended. uded a Care Plan Addendum in revealed the resident was at ee to recent falls. An update on osed in lowest position and in requested. Frequent note dated 6/3/13 at 2:35 found the resident in another the floor in front of his/her eel was trying to get up to go to entified staff had assisted the room every hour and the ion at times. Staff assessed and no injury, and would for changes in condition. The	F 32	73		
	resident's status an plan of care to ensure A nurses' note date revealed the reside restroom and staff received antibiotic traceived but was instructions, especitoileting. "A high fall include chair and be re-educate and reerealed the resident traceived and resident traceived and traceived and traceived antibiotic traceived and traceived antibiotic traceived antib	nce staff reassessed the d reviewed or updated the life it remained effective. d 6/18/13 at 8:44 A.M. Intrepeatedly asked to use the edirected, and the resident herapy for a urinary tractent did not follow commands able to follow small direct ally during transfers and risk and measures in place ed alarm. Nursing continue to mphasize safety cues." d 6/20/13 at 1:27 A.M. Int was "very agitated" that be out in the common area in				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG		COMPLETED	
		175532	B. WING_			C 12/19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	S, CITY, STATE, ZIP CODE FEAST	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	area adjacent to the resident tried to star fell to the floor befor him/her. The residen his/her forehead. The to whether staff atteresident was agitate updated the resident was augusted visual supervision, be continued. The note chair alarm. Review of a note da revealed the resident evening." The resident was found his/her walker. At 11 resident was found his/her wheelchair in note also revealed, requested to manage evidence staff reass and reviewed or updensure it remained and reviewed and reviewed or updensure it remained and reviewed or updensure it remained and reviewed and reviewed or updensure it remained and reviewed and revie	chair. The resident sat in the nurses station when the dup from the wheelchair and e the staff could get to not received an abrasion to e record lacked evidence as mpted to determine why the d, reassessed the resident or t's plan of care. The dated 6/28/13 at 6:00 P.M. Intions included continuous and alarm and fall mat to floor e made no mention of the sted 6/28/13 at 7:04 A.M. In the sted 6/28/13 at 6:00 P.M. In the sted 6/	F3	23		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175532	B. WING		C 12/19/2013	
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	12/13/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 323	Coumadin therapy. last week with incre X-ray was obtained a minimally impacted dorsum of the distal During an interview 12/12/13 at 4:36 P.I resident had confus was not reliable to ureported, if he/she tone day, the resident had confus was not reliable to ureported, if he/she tone day. Staff also impulsive, and did gitimes when the resident to snack which helped and he/she had a bed and chair reported he/she che hours, but when the the resident needed all times. During an interview Consultant C report investigations for the experienced to shot times of the falls, if been effective, or if	viors. [Gender] is currently on [Gender] did undergo a fall ased pain over the weekend. It did show that [gender] had cortical fracture at the	F 32	,		
	have been complete Consultant C report note for the fall on 6 what the resident w Consultant C report identify an alarm wa	ed to obtain that information. ed, by looking at the nurses 6/27/13, he/she could not tell as attempting to do. ed the previous notes did as in place and the note for the aled staff requested one.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED	
		175532	B. WING			C 12/19/2013	
	NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CO 2114 N 127TH CT EAST WICHITA, KS 67228		2/19/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	happened to the alar the nurse aide docur aides last assisted that 9:23 P.M. prior to reported he/she expresidents more frequencies was not effect safe. Consultant C afall history and the resident's room if the Consultant C reported follow the admission first came into the faread Admission CAAs, state comprehensive care reported he/she the effect by 6/10/13. During an interview A.M. on 12/16/13, he had dementia and diphysician H reported investigate falls to know differently to he Physician H reported fall, but did need to fall, but did need to fall the consure staff provided as planned, provided ensure the current fall effective. Review of resident signed physician's or revealed diagnoses	ed he/she did not know what rm. Consultant C reviewed mentation and reported the ne resident and documented the fall. Consultant C ected staff to check on an antity if doing so every 2 ive in keeping the resident also reported, based on the esident's impulsive behavior, not have been left alone in the eresident was restless. If the care plan when the resident cility. After completing the aff had 10 days to put a plan in place. Consultant C comprehensive care plan in with Physician H at 10:00 e/she reported the resident id need a lot of attention. If he/she expected staff to now what things could be elep prevent further falls. It staff could not prevent every	F 3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175532	B. WING				C 19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRE 2114 N 127TH (WICHITA, KS			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	K (EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B ISS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	respond to the insucondition when the body becomes con (inability of the kidr concentrate urine a depressive disorde the prostate. The electronic recorresident admitted to Review of the Adm dated 9/30/2013 refalls. Review of the reside (Minimum Data Servealed the reside for Mental Status) simpairment). It revelimited assistance of walking and locomolast month prior to a months prior to admension and the prostate of the Fall of dated 10/13/13 revlimited to extensive transfers and amburisk for falls. The reambulation, needed slowly and stand for Review of the undarevealed the reside revealed the resident procession and the prostate of the undarevealed the resident procession and the procession of the undarevealed the resident procession and the procession of the undarevealed the resident procession and the procession of the undarevealed the resident procession and the procession of the undarevealed the resident procession and the procession of the undarevealed the resident procession and the procession of the undarevealed the resident procession and the procession of the undarevealed the resident procession and the procession of the undarevealed the resident procession and the procession of the undarevealed the resident procession and the procession of the undarevealed the resident procession and the procession of the proc	insulin made or the body can't din), congestive heart failure (a heart output is low and the gested with fluid), renal failure neys to excrete wastes, and conserve electrolytes), r, and inflammatory disease of ord face sheet revealed the orthe facility on 9/30/13. ission nursing assessment electrolytes admission/5 day MDS assessment dated 10/13/13 and had a BIMS (Brief Interview score of 6 (severe cognitive ealed the resident needed of 2 people for bed mobility, of 1 person for transfers, otion. The resident had a fall in admission, and in last 2-6 mission, but had not	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '			(X3) DATE SURVEY COMPLETED	
		175532	B. WING				C 19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		21	REET ADDRESS, CITY, STATE, ZIP CODE 14 N 127TH CT EAST ICHITA, KS 67228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	people for transfers, assist, and needed and repositioning. "Tand PRN (as needed x 2 (person and place had dementia/Alzhei Review of the compital/1/13 indicated the and unsteady gait and unsteady gait are Review of a nurses in P.M. revealed the reconfused at times with Another note on 10/2 the resident alert, and memory loss. A nurses note on 11 the "resident in the bathroom." The resident to walk without a way evidence staff proviplanned, reassessed reviewed and/or updensure it remained experienced and complete lower rib area. Staff received an order for Review of a Prelimin Services Corporation reason for the X-ray	ambulated with 2 person assistance of 1-2 ambulated with 2 person assistance of 1 for turning foileting q2hrs (every 2 hours) d)." The resident was oriented be), disoriented, forgetful and imer's. The resident had an actual fall and poor balance. In the dated 10/15/13 at 4:11 sident was alert and ith memory loss. 26/13 at 10:06 A.M. revealed and confused at times with 27/113 at 11:47 A.M. revealed and confused at times with 27/113 at 11:47 A.M. revealed and confused at times with 27/113 at 11:47 A.M. revealed better stated he/she was trying liker. The record lacked ded care and supervision as at the resident's status and lated the plan of care to diffective. 28/2013 at 2:09 sident continued on fall ained of pain in the right notified the physician and rear ib X-ray. 28/2013 at 11/2/13 revealed a different fall 11/1/13. The rib. No underlying pleural	F	323			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		175532	B. WING		C 12/19/2013		
	ROVIDER OR SUPPLIER	FREEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	,		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROP	JLD BE COMPLETION		
F 323	reported he/she did investigation for the on 11/1/13. During an interview with Direct Care stresident was at risk with a gait belt for a 1:31 P.M. on 12/12 needed to stay in the extra time in the rewould get up withour eported the resident to call for help. Review of the Aide November 2013 re (restorative): Take during waking hour day that month. That 11:42 and 11:43 the resident to the at 1:45 P.M. on 12 the charting prograstaff was not initiall needs. When a resident at the control of the control of the charting prograstaff was not initially needs. When a resident at the control of the control of the charting prograstaff was not initially needs. When a resident at the control of the charting prograstaff was not initially needs.	age 42 32 P.M., Administrative staff A d not know the location of the e fall the resident experienced at 12:40 P.M. on 12/12/13 aff J, he/she reported the c for falls and used a walker ambulation and transfers. At 1/13, staff J reported staff he room if the resident needed stroom because the resident at calling for help. Staff J nt was too confused to know Documentation Report for evealed, "Toileting Program to bathroom every 2 hours are to be documented on each the report revealed staff charted A.M. on 11/1/13 that they took bathroom. During an interview 1/12/13, Consultant C reported m and cueing information for y set up for individual resident ident admitted to the facility, a taking to the bathroom every	F 32	,			
	residents. Staff C r specify whether staresident, or not to I During an interview Administrative nurs not have any evide	natically turned on for all eported the direction did not aff needed to stay with the eave the resident unattended. If at 2:08 P.M. on 12/12/13, sing staff B reported he/she did not not show an investigation and to determine whether staff					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		175532	B. WING _			C 12/19/2013	
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	I	12/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	had nothing to show resident unattended. During an interview Physician O had no regarding the reside. The facility failed to staff provided care a remained appropria. Review of residen orders dated 9/16/1 including the following malignant (a medicatumors, to become most familiar as a commost familiar as a common familiar as a	at as the resident needed, and with that staff did not leave the lon the toilet. at 12:30 P.M. on 12/18/13 additional information ent's fall. investigate a fall to ensure as planned and interventions te. at #4's signed admission 3 revealed diagnoses ng: rehabilitation procedure, al condition, especially with progressively worse. This is haracteristic of cancer) ronchus and lung, shortness	F 3.	23			
	resident admitted to Review of the admis Data Set) assessme resident had a BIMS Status) score of 15 extensive assistanc transfers, locomotio assistance of 1 pers locomotion on the u in the 6 months prio non-injury fall since	emia. Indicate sheet revealed the of the facility on 9/14/13. Indicate sheet revealed the of the facility on 9/14/13. Indicate sheet revealed the second sheet of 1 person for bed mobility, off unit, needed limited son for walking, and onit. The resident had no falls or to admission, and had 1					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		175532	B. WING _			C 12/19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	EITY, STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	unawareness, weak pain. The resident hat time without injury, a because he/she was chair to the bed. The within reach at all tine education to use the resident had impaire medications which in Review of the the Ad 9/21/13 (staff failed the resident admitted to resident at risk for faprogram every 2 hour equest, the resident person for transfers, ambulated with assist revealed the resident resistive to care/non not have any fall interest that time. Review of the resident revealed (initiated or confusion, staff needeach time in the resilight to call for assist include the resident to ally living) needs, of after the resident expon 10/9/13. Review of a nurses in P.M. revealed the resident expon 10/9/13.	for falls due to safety mess impaired mobility and ad fallen at the facility one and stated that he/she fell be trying to transfer from the experience resident had a call light mes, and staff provided call light. It also revealed the ad balance, and received mereased the risk for falls. It mission Care plan dated to initiate until 7 days after the the facility) revealed the alls. It revealed a toileting ars and at the resident's to needed assistance of 1	F3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		175532	B. WING		C 12/19/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	12/19/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 323	himself/herself. A nurses' note on 9/1 revealed the resident bathroom, and the relight all the time. Staf use the call light wheresident's bed was in light within reach. A nurses' note on 9/1 "Fall follow up- No injuncted, chronic pain or remind res. (resident The resident's medic description of the fall resident immediately lacked any description occurred, whether stacurrent needs, or any care plan to ensure the effective. A note on 9/19/13 at performed a head to resident, assessed the and revealed the resistent on the important physician, and family resident on the important physician, and reducation or notify resident's status, or feducation had been of the physician of the physician of the important physician or notify resident's status, or feducation had been of the physician of the physician of the important physician or notify resident's status, or feducation had been of the physician of the physician of the physician of the important physician or notify resident's status, or feducation had been of the physician of th	6/13 at 3:34 A.M. also walked unsteady to the sident did not use the call fre-educated the resident to n in need of help, the low position and the call 9/13 at 11:09 A.M. revealed, furies notes- No acute pain continues, Cont (continue) to to ask/wait for assistance." all record lacked any or assessment of the following the fall. The record nof the the fall that aff reassessed the resident's review or updates to the ne interventions remained 8:50 P.M. revealed a nurse toe assessment on the ne interventions remained 8:50 P.M. revealed a nurse toe assessment on the ne interventions remained ctor of nursing, the and re-educated the tance of using the call lighting up without assistance. Clude the reason for the ring parties related to the ollow-up as to whether the	F 3:	23	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		COMPLETED		
		175532	B. WING			C	
	ROVIDER OR SUPPLIER ALTH AND REHAB AT			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	1	12/19/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 323	but did receive a skir again re-educated the light when in need of evidence where staff resident, or reviewed ensure it remained ensure it report of the documented at 9:59 9/20/13, and did not A.M. on 9/21/13. The revealed no staff ask to toilet within or at 2 and needs that even having confusion wit required assistance resident had his/her call light within reach. A nurses' note on 10 at 9:15 P.M., someof floor. The resident we complained of pain it resident said it "just the physician, and the building to the hospic completed after the statements from staff statements lacked in saw the resident, an behavioral state at the failed to determine we	nt denied pain at that time, in tear on the left elbow. Staff he resident to use the call if help. The record lacked if staff reassessed the d/updated the care plan to effective. Interest the time that it is the provided of the care plan to effective. Interest the time that is the care plan to effective. Interest that is the care plan to effective. Interest the call the call the call the care plan to effective. Interest the call the care plan to effective. Interest the call the care plan to effective. Interest the call	F 3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		175532	B. WING _			C 2/19/2013
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	•	2110/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Continued From pag	ne 47	F 3	23		
	and whether the call found the resident. I marked as a predisp describe or include f the clutter was or if it. During an interview of 12:40 P.M. on 12/12 remembered the resone point, and the resone point, and the resone point, and the resone he/she had to make not in the resident's resident to the bathre thought the resident following directions aup in the morning, but acted fine the rest of needed assistance fused a gait belt and. At 11:47 A.M. on 12/13 G reported the resident had the to do things, but staff problems with his/he stood up. The resident would lower, and the reported he/she expresident about every history of falls. When the facility, the resident assistance, but as tin needed more cueing daily tasks.	light was on when staff The investigation had "clutter" osing factor, but did not urther investigation into what it affected the situation. with Direct Care staff J at /13, he/she reported he/she ident had a bed pad alarm at esident had a few falls tripping xygen cord. Staff J reported sure the oxygen tubing was way when staff helped the oom. Staff J reported he/she had the most trouble with and stability just after waking ut after that, the resident form one staff member, and walker for locomotion. /12/13, Licensed Nursing staff ent was a very big fall risk. e physical and mental ability of G reported the resident had er oxygen level when he/she ent's oxygen saturation level er resident would fall. Staff G ected aides to check on the resident first admitted to ent would call and ask for me progressed, the resident and reminding to complete				
	staff B and Consulta	6/13, Administrative Nursing nt C both reported the lls on admission and staff				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175532	B. WING		C 12/19/2013
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE				STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	12/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 323	the resident's risk or	ge 48 the resident every 2 hours. If needs increased, both staff reported they expected staff	F 32	3	
	to increase the frequesident.	at 10:00 A.M. on 12/16/13			
	Physician H reported facility for reconditionable to go home. Phresident did sustain fall, but was not a sureported he/she exp to know what things help prevent further	d the resident admitted to the ning, and strengthening to be nysician H reported the a fracture to the arm from the urgical candidate. Physician H ected staff to investigate falls could be done differently to falls. Physician H reported ent every fall, but did need to			
	The facility failed to each fall to determin remained effective, pupervision/assistan resident from ambul independently, and the care plan after experience.	thoroughly investigate after lie if the current interventions corovide lice as planned to prevent the lating to the bathroom failed to review and update			
	sheet signed by the revealed diagnoses specified aftercare for replacement by other osteoarthrosis (conditional without inflammation Review of the electrons and the signed statement of the sector of the signed statement of the sector of the	t #6's physician's orders physician and dated 11/27/13 including the following: other collowing surgery, hip joint for means, and general lition of chronic arthritis n) involving multiple sites. conic Face Sheet revealed the the facility on 9/12/13.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		175532	B. WING		C 12/19/2013		
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST NICHITA, KS 67228	1 12/19/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
F 323	Data Set) assessmeresident had okay sineeded limited assist extensive of 2 for tradiction on unit, and occur. The residuant months prior to a to determine if the months prior to admexperienced a fracture experienced no falls. Review of the Fall Codated 9/19/13 reveat the facility for long to rami fracture. The reweeks" prior to admiphysical. The reside a history of a total kinequired extensive a members for many aliving). The resident needed" pain medicurine at times. Review of the undata revealed the resider hours for bathroom for transfers, used a ambulated with assirisk for falls, and needer repositioning. The fall the resident experienced the resident experienced the resident pain medicurine at times.	sision/5 day MDS (Minimum ent dated 9/19/13 revealed the nort and long term memory, stance of 1 for bed mobility, ansfers, walking in room and and limited assistance of 2 for and locomotion off the unit did ent experienced a fall in the dmission, staff were unable esident had a fall in the 2-6 ission or if the resident are in that time. The resident are in that time. The resident are in that dealth admitted to the resident admitted to earn care and was post pubic esident had a fall "about 2 ission per the history and and that chronic knee pain with the replacement, and the replacement, and the resident admitted to earn care and was incontinent of a sistance of 1-2 staff and a sistance of 1-2 staff and a sistance of 1 staff a walker and wheelchair, staff a walker and wheelchair, staff one and a gait belt, had eded assistance of 1 person the care plan did not reflect the erienced on 9/15/13.	F 323				
	revealed the resider	ent's comprehensive care plan nt had an actual fall with no teady gait, poor balance, poor					

A. BUILDING	(X3) DATE SURVEY COMPLETED		
	C / 19/2013		
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	719/2013		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
Continued From page 50 communication/comprehension (the initiated problem on 11/14/13 and revised on 12/5/13). It revealed the resident needed a safe environment with clutter free, and clean floors, a working and reachable call light, the bed in low position at night; slide fails as ordered, handrails on the walls, personal items within reach (initiated on 12/5/13), be sure the call light is within reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance (12/5/13). The care plan directed staff to check range of motion daily (initiated 12/5/13), continue interventions on the at-risk plan (initiated 12/5/13). For no apparent acute injury, it directed staff to determine and address causative factors of the fall (initiated 12/5/13). The comprehensive care plan did not include the resident's current ADL abilities or needs from staff. Review of a nurses note dated 9/15/13 at 10:54 P.M. revealed staff found the resident sitting on the floor. The resident said he/she was attempting to go to the bathroom by himself/herself and missed some steps. The resident could move all extremities without any difficulty or discomfort, and had no injuries. Staff instructed the resident to ask for help and not attempt to transfer himself/herself. The record lacked evidence the facility reassessed the resident and reviewed/updated the care plan to ensure the interventions remained effective. Review of the Documentation direct staff input into an electronic charting system) for 9/15/13 revealed no indication staff had assisted the resident to the restornow within 2 hours prior to the			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175532	B. WING		ı	C 2/ 19/2013
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE				STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	Continued From page	e 51	F 32	23		
	P.M. revealed the writher resident was on the resident was all all extremities. Staff a into the recliner. "Befinite pitcher was refilled, pwithin reach. Educate importance of using or record lacked evident resident's needs and care planned to ensuremained effective. Observation at 2:20 Fither resident stood neheld onto a walker. It applied a gait belt to members held the garesident as they pulled the staff members we resident's pace as the the perimeter of the fillen, but did not remote fallen, but did not remote fall. The resident resome things on his/he he/she got help for. A revealed the resident and general sident and general sident and general sident and general sident resident resident resident resident resident revealed the resident his/her call light and general sident and general sident and general sident and general sident resident re	P.M. on 12/11/13 revealed xt to Direct Care staff F and Direct Care M walked over, the resident and the two staff it belt and walked with the end the wheelchair behind. alked slowly and at the energiate resident ambulated around house. It 3:20 P.M. on 12/11/13, the she remembered he/she had nember what caused him/her eported he/she could do er own and some things At that time, observation sat in his/her recliner with grabber within reach.				
	During an interview a Direct Care staff F ar reported the resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		175532	B. WING			C 12/19/2013	
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE				STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	rest breaks. Staff M try to go to the bath did not always call for check on the reside M reported they need every 2 hours, but Stadid rounds if not chabecause they like to because they like to During an interview Administrative staff fall investigations of 9/15/13 and 11/14/2. The facility failed to planned for the resist to determine the cast interventions remainfalls. Review of resider sheet signed 11/27/ following diagnoses procedure, orthoped muscle weakness. Review of the Admi Set) assessment daresident had a BIMS Status) score of 14 resident needed eximobility and locomor assistance of 2 for the room/corridor and locesident had no fall admission, had a fafracture related to a status of the status of	was unsteady, and needed reported the resident might room by himself/herself and for help so staff needed to int frequently. Staff F and Staff eded to check on residents staff F and Staff M continually arting or assisting a resident o "keep an eye on" everyone. at 7:55 A.M. on 12/16/13, A reported staff could not find ompleted for the falls on 13. provide supervision as dent, and investigate each fall use and whether the current need effective to prevent further at #5's physician's orders to other specified rehabilitation dic aftercare, and generalized ssion MDS (Minimum Data and 6/20/13 revealed the 6/30/13 revealed the 15/30 (Brief Interview for Mental (cognitively intact). The tensive assistance of 1 for bed option off unit, extensive	F 33	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		175532	B. WING		C 12/19/2013		
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE				STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 323	Review of the Quart 12/1/13 revealed the (cognitively intact). extensive assistance mobility/transfers, who comotion off the unoccurred only 1 or 2 assistance of one punit. The resident has (except major) since Review of the Fall Cofor 6/20/13 Admissionathigh risk for falls, and unsteadiness from had a right hip replaimpairment since the had poor safety away up unassisted and retransfers. The resider related to pain, recemedication and there Review of the resider an actual fall on 7/1 weakness and unstance hospitalization. The replacement, had contiss and required the resider and the resider that the r	Il with no injury since fall with major injury. Iterly MDS assessment dated to resident with a BIMS of 15. The resident needed to of 2 staff for bed walking in his/her room and unit, walking in the corridor to times, and needed extensive the erson for locomotion on the aid 2 or more falls with injury to the prior assessment. CAA (Care Area Assessment) on MDS revealed the resident The resident had weakness from a recent hospitalization, accement, and had cognitive the surgery. The resident now areness, attempted to stand required assistance with the ent also had restlessness the event also had rest	F 32	3			

OLIVILIV	OT OIT MEDIO, ITE &	MEDIO/ ND OLIVIOLO				<u> </u>	7. 0000 0001
', '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7 5 6 5	_		, ا	2
		175532	B. WING				19/2013
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
A1//TA 11F	41 TU 4ND DEUAD 4T F	NEEDO 001/E		2	114 N 127TH CT EAST		
AVIIAHE	ALTH AND REHAB AT F	REEDS COVE		V	VICHITA, KS 67228		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
					DEFICIENCY)		
F 323	04	- 54					
F 323	Continued From page		-	323			
		staff added dycem (non-slip					
		flatable ring to prevent					
		more comfortable bed and					
	I -	help relieve coccyx pain					
		out of bed, and provide					
	,	n) for constipation due to					
	increased anxiety wh	ue to discomfort. Staff					
		the resident to not stand					
	without assist, and th						
	It directed staff to ser						
	other residents to pre						
	leaving the table afte						
		and toilet after eating					
		hen anxious, it also directed					
	I *	dent in the dining area,					
	•	ctivity cards, dominoes,					
	I -	bed alarm to the bed once					
	•	6/18/13 and revised on					
	,	3, staff added providing a					
		h return demonstration of					
	the pendant use dem						
		is with culture and sensitivity					
	on 12/2/13, receive o	xygen at 2 liters to maintain					
	an oxygen saturation	at 92% or with complaints of					
	shortness of air (initia	ated 12/1/13). It also					
	revealed, when not ir	bed, encourage the					
	resident to sit in the o	lining area or community					
	television area, and p	provide with activity as					
	available (initiated 7/2	20/13 and revised 11/25/13).					
	Review of the Salf Co	are deficit care plan (initiated					
		e resident had recently had a				ſ	
	hospitalization for a r	-				ĺ	
		ssistance with transfers and				ĺ	
		wheelchair for his/her				ĺ	
	primary mode of loco						
		akness. The care plan				ĺ	
		required extensive assist				ĺ	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		175532	B. WING _			C 12/19/2013	
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE				STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	12/19/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	walker, and could prodistances. Review of a nurses of revealed the resident himself/herself to the assistance from nurse resident had a large the left eye. The recording the left eye. The recording the left eye. The recording the plan of control of the left eye. A note on 9/24/13 at aide entered the resident on his/her kneed again lacked the resident on his/her kneed again lacked the resident's status plan of care to ensure the resident lying on his/reported his/her chain and it happened so for stop from falling. Assistent received 2 so the record failed to it to when staff last assist had followed the resident further falls. On 11/1/13 at 3:49 Processing to the reverse of the resident falls.	leting, ambulated with a opel himself/herself short note on 9/17/13 at 10:23 A.M. It was trying to help bathroom without sing staff and fell. The elevated bruise superior to ord lacked evidence staff ent's status and reviewed or care to ensure it remained 3:40 P.M. revealed a nurse dent's room to find the nees facing his/her bed. The evidence staff reassessed and reviewed or updated the eti remained effective. 3 at 8:28 P.M. revealed, at P.M., staff heard someone an area around a resident t's room, staff found the her back. The resident r slid out from under him/her east that he/she could not essment revealed the kin tears to the right forearm. Include any investigation as sisted the resident, if staff dent's plan of care, or if the remained effective to help	F3	23			
		e/she was trying to get into over. The resident had					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		175532	B. WING _					C 19/2013
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE				2114 N 1	ADDRESS, CITY, STATE, ZIP CODI 27TH CT EAST (A, KS 67228	E	1 12/	13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 323	lacked any indication determine if staff had provided adequate sinterventions remain further falls. A nurses note dated the resident was fou bed by an medication he/she was trying to resident denied presattempted to ambular resident needed ass. The note revealed the complained of soren because he/she fell lacked any investigated the resident to timely manner, whet resident's plan of call interventions remain further falls. Observation on 12/1 the resident sat in a table and ate the mostarted to slide down	and place. The record in staff investigated the fall to d followed the care plan, upervision, or if the current ed effective to help prevent 11/22/13 8:12 P.M. revealed and on the floor next to his/her an aide. The resident stated go to the rest room. The sing the call light and te unsupervised. The istance of one staff member. He resident denied pain, but ess to his/her right side on the trash can. The record tion to show staff assisted or go to the bathroom in a her staff followed the	F	323	DEFICIENCY)			
	wheelchair brakes, president and assisted his/her wheelchair, of they assisted him/her. During an interview a Licensed Nursing staneeded one on ones.	ff members locked the blaced a gait belt around the d the resident to sit back in the blace in the blace in the second to help as ser. at 11:20 A.M. on 12/16/13 aff N reported the resident to the second traveled from point the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL1 A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		175532	B. WING _			C 12/19/2013	
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE				STREET ADDRESS, CITY, STATE, ZIP C 2114 N 127TH CT EAST WICHITA, KS 67228	CODE	12/13/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE THE APPROPRIA		
F 323	reported he/she had severy 30 minutes or some the resident liked to some and had confusion at make sure they check During an interview who with the facility failed to interesident experienced.	k to his/her room. Staff N staff check on the resident to at night. Staff N reported pend time in his/her room, times. Staff just needed to ked on him/her frequently. With Administrative staff A at 3, he/she reported staff estigations for the falls on 1, and 11/22 at that time. Investigate multiple falls the to help determine the ly determine effective	F	323			